AADAC Annual Performance Highlights

for 1996/97

AADAC
Alberta Alcohol and Drug Abuse Commission
An Agency of the Government of Alberta

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Message from the Chair

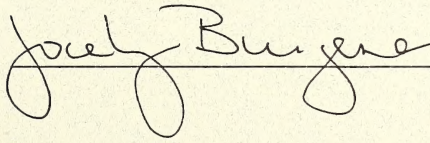
On behalf of AADAC's Commission Board and staff, I am pleased to present the 1996-97 Annual Performance Highlights for the Alberta Alcohol and Drug Abuse Commission. In presenting this report I would like to acknowledge the contribution of Mrs. Bonnie Laing, MLA for Calgary Bow and Chairperson of the Commission from August 1993 to March 1997. It is her efforts on behalf of AADAC that are reflected in this 1996-97 report.

During 1996-97, an independent committee of MLAs critically reviewed AADAC's mandate and relationship to Regional Health Authorities. In its report, the Mandate Review Committee clearly acknowledged the Commission's strength in working with communities, families and individuals in addressing the problems of addiction. The Committee endorsed the Commission as an independent Provincial agency providing access to a coordinated system of local, regional and provincial addictions services. The Mandate Review Committee noted that it would be a challenge for AADAC to maintain accessible, high quality services in the face of increasing community demand for services and shrinking resources.

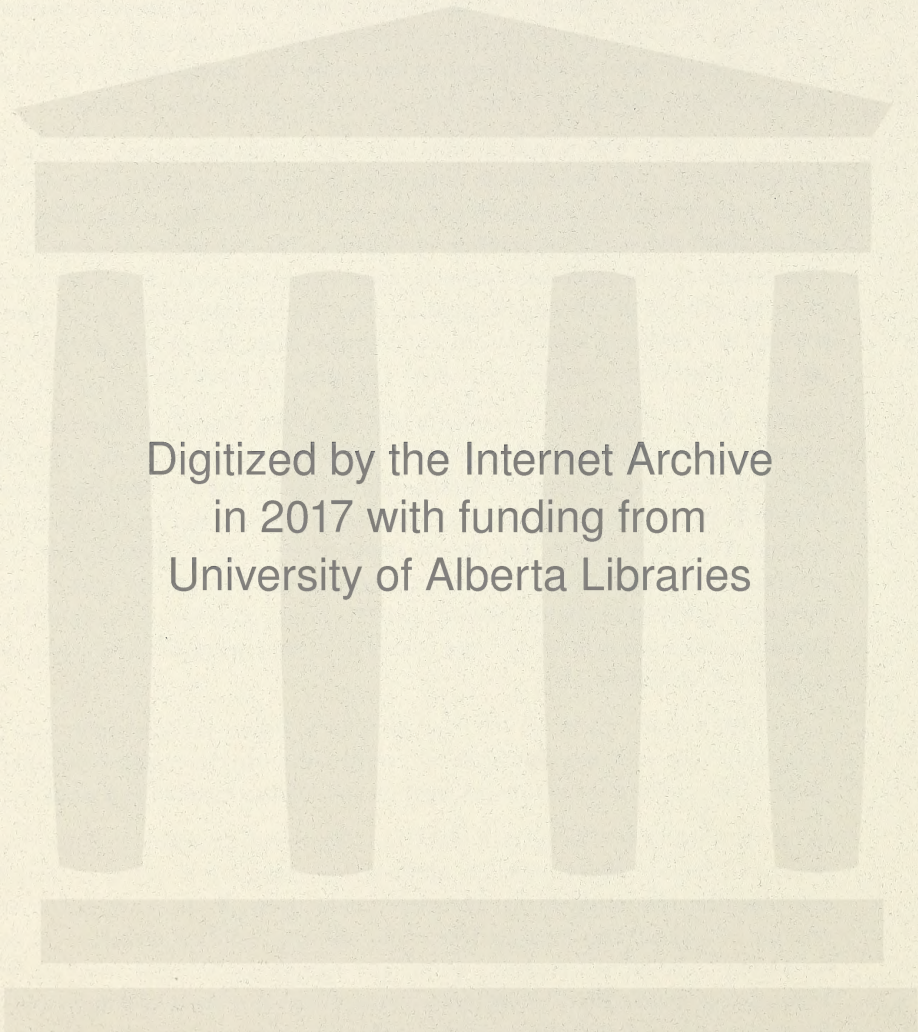
Priorities for the Commission over the 1996-97 fiscal year focused on ensuring continued access to effective services, with particular attention to services for youth and problem gamblers. Both areas showed increased service volumes during the year. Outcome measures for the 1996-97 year show a sustained increase in overall service volumes for treatment (7% increase in number of people treated over 1995-96 and 14% increase over 1992-93) and prevention/education (26% increase in number of people reached over 1995-96 and 13% increase over 1992-93). During 1996-97, AADAC clients continued to report high levels of satisfaction with access to services, the quality of services delivered and the impact of AADAC programs on their lives.

In 1997-98, AADAC's challenge will be to continue to deliver excellent addictions programming while addressing increasing demand for services, changing public expectations, as Alberta moves toward the twenty-first century and full participation in a global economy.

In the short time I have been Chair of AADAC I have come to realize the huge social, economic and human costs of addiction. Although it is unrealistic to expect to completely eradicate addiction, it is fortunate that addictions can be treated for the most part in non-hospital settings. This means that the majority of Albertans with addiction problems can be treated in their home communities. If more intensive interventions are required, these are available on a regional or provincial basis. I look forward to learning more about addictions and the work of the Commission as I continue my tenure as Chair. Like my predecessors, I am committed to maintaining contact with the communities we serve. I invite comments on this report and the work of the Commission from you, the reader. Your comments will help us ensure the relevance of what we do.



Member of the Legislative Assembly
Chair, Alberta Alcohol and Drug Abuse Commission



I. Purpose

AADAC formally reports its performance and financial statments in the Ministry of Community Development's ***Annual Report***[1] each fiscal year. The annual report provides enough information for most Albertans' needs. These highlights are for AADAC management and staff, people who work in related community agencies, education, health, social services, justice and people in other addictions agencies.

II. Overview of AADAC's Mandate and Services

Under the Alberta Alcohol and Drug Abuse Act (amended in 1994 to address concerns about gambling problems), the Commission's mandate is to operate addictions treatment and prevention programs, to undertake research, as well as to fund and assist others in these endeavors. AADAC views addictions problems as requiring direct action through a continuum of appropriate services available to the individuals affected, their families, and their communities. By delivering services and working closely with other community-based agencies at 39 locations throughout the province, AADAC provides a holistic alternative to higher cost hospital and medical services.

Our Goal: ***To assist Albertans in achieving freedom from the abuse of alcohol, other drugs and gambling.***

A. Service Overview

AADAC's business plan[2] has addressed this goal by maintaining accessible, efficient, client-relevant and effective services in the following areas:

Community Outpatient and Prevention Services' purpose is to increase the capacity of communities to effectively address issues related to alcohol, other drugs, and gambling. Services are available throughout the province and form the core of AADAC's locally available services.

Crisis Services' purpose is to provide safe withdrawal from the extreme effects of alcohol and other drugs, and to provide referral and counselling on an emergency basis. Clients can contact crisis services directly or by making simple arrangements with local community outpatient services. As well, the *Gambling Help Line* is available provincially.

Residential Treatment Services' purpose is to assist severely dependent clients in their recovery from addiction to alcohol, other drugs and gambling. Clients who wish to enter treatment can contact residential treatment facilities directly or by making simple arrangements with local community outpatient services.

Research, Information and Monitoring Services' purpose is to ensure prompt access to accurate and current information on issues, trends, and research in the addictions field. Services are delivered provincially. Research, Information and Monitoring Services can be reached directly, through community outpatient and education services, or through AADAC's Home Page at *http://www.gov.ab.ca/~aadac*.

AADAC continuously monitors the quality of these services. Through ongoing surveys, clients rate their access to, and satisfaction with, the services they use. They also assess the effectiveness of those services (outpatient and residential treatment

clients rate effectiveness three months after the completion of treatment; others rate services as they are delivered). Efficiency is measured by the cost per treatment client or prevention contact; these costs include all funds invested in providing service, including local, regional and provincial administration. Other measures are under development for Research, Information and Monitoring Services and for some prevention and education services.

B. Key Business Results

Priorities for the Commission over the 1996-97 fiscal year focused on ensuring continued access to high quality services with particular attention to services for youth and problem gamblers. As well, an in-depth review of the Commission by an external Committee of MLAs[3] was completed. Finally, the Commission successfully achieved, within the three-year target, the full 20% reduction in the operating grant from Government and operated at 1986-87 budget levels.

The Commission's business plan was developed in the context of overall affordability and addiction service needs in Alberta. Despite continued declines in alcohol and other drug use[4,5,6], the social cost of addiction remains high[7]. Because addiction varies considerably from person to person, there is no measure that is both simple and precise. However, estimates[8] of the risk of alcohol problems suggest that 20% of adults are at high risk for developing alcohol-related problems and that an added 5% are at major risk of becoming dependent on alcohol and having severe problems as a result. In Alberta, these two groups would represent over 512,000 people. In addition, AADAC's mandate was broadened to include problem gambling services in 1994. The Commission continued to develop and provide new services for problem gambling. A major study using the most reliable methods available estimated that 5% of adult Albertans (over 100,000 people) are either at risk for or experiencing a severe degree of problem gambling[9].

Communities expressed continuing demand for services in a number of ways, including requests for funding and for services and increased use of existing services. To meet this demand, staff and management in AADAC and the agencies AADAC funds employed a wide variety of strategies to improve access to services. Services for youth and problems related to gambling were priorities Commission-wide.

Youth initiatives included:

- consolidating youth services in Calgary and Edmonton to single sites in order to increase efficiency and client services;
- increasing collaboration with Children's Services and other key players in services for youth; and
- developing a new model for prevention programming.

Gambling initiatives included:

- enlisting the support and encouragement of Gamblers Anonymous;
- developing a pilot day treatment program for gamblers;
- developing a series of specially targeted resources and training material and
- sponsoring studies on youth gambling and gambling in Native communities.

Consolidation of Adult Services in Calgary and Edmonton continues to be a goal in 1997-98, as suitable sites for these services have not been found. This goal was part of AADAC's 1995-96 business plan.[10]

In the third year of continuous performance measurement, there is increased evidence that staff and management have begun to "manage what is measured," as they have shifted the focus of their work from maintaining budget and service levels to increasing client satisfaction, service efficiency and effectiveness. In the context of continued community demand for service and reduced operating capital, the MLA's Mandate Review Committee noted a concern for the Commission's capacity to continue to provide high quality services.[3]

In summary, the key focus of the Commission has been on continuing to ensure access to meet community demand, particularly for adolescent and gambling services, and to reduce reliance on government funds.

The key results achieved are:

- Overall treatment admissions increased 7% and prevention contacts increased 26% over the previous fiscal year.
- During the year, AADAC clients continued to report high levels of satisfaction with access to services, the quality of services, and the impact of AADAC programs on their lives.
- Addiction services continue to provide a good return on investment. The addictions literature reports that the rate of return to taxpayers ranges from $4.31 to $12.58 per dollar invested, depending on the circumstances, as clients return to productive employment, reduce their criminal activity and decrease their use of health care.

II. Operational Results and Analysis

AADAC delivers service in four areas: Community Outpatient and Prevention Services; Crisis Services; Residential Treatment; and Research, Information and Monitoring Services. This section includes a summary of services provided, benchmarks for AADAC's overall services and the objectives and results achieved for each business area. Unless otherwise noted, results reported in this section are documented in detail in *AADAC Service Monitoring Systems Annual Performance Highlights, Working Papers.*[11]

A. Service Delivery Summary

In 1996-97, AADAC services to Albertans increased substantially over 1995-96, continuing a trend of increased service demand. Total treatment services admissions increased to 35,613, a 7% over the previous fiscal year (a 14% increase over 1992-93) and prevention-education services contacts increased 26% over the previous year (a 13% increase over 1992-93). The following table details service delivery for 1996-97 and summarizes changes from the previous fiscal year.

Figure 1

Services Delivered

	Treatment Admissions	Crisis Services	Contacts	Information Products
Community Outpatient and Prevention Services				
Prevention and education			151,483	
Training			7,491	
Outpatient counselling services	18,577			
Day treatment	1,927			
Crisis Services				
Detoxification	10,257			
Overnight shelter stays		84,796		
Gambling Help Line counselling		3,011		
Residential Treatment Services				
Short-term residential	4,203			
Long-term residential	649			
Research, Information & Monitoring Services				
Information resources, communications & newsletters				548,665
Information development initiatives				193
TOTALS 1996/97	**35,613**	**87,807**	**158,974**	**548,858**
1995/96**	33,248	80,148	126,004	614,030

* *Unless otherwise noted, statistics for adults and adolescents are combined in the report.*

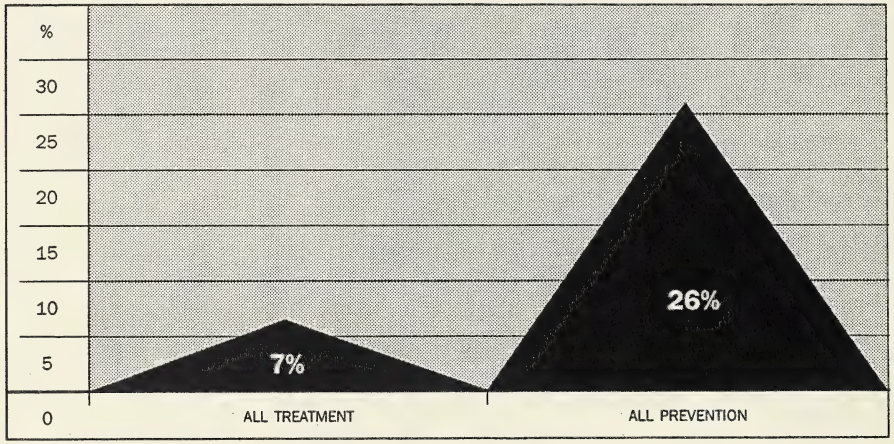
** *Treatment admissions and contacts revised from 1995-96 reports.*

The following chart highlights key changes in service delivery experienced over the 1995-96 to 1996-97 fiscal year.

Figure 2

Percentage Changes in Service Delivery

1995/96 to 1996/97



Treatment:

Key Change: Across all treatment and detoxification services, admissions increased 7% over 1995-96. Within specific services, treatment admissions increased in detoxification (up 14%) and outpatient counselling (up 5%). Admissions declined, as planned, in short term residential treatment (-3%) and long term residential treatment (-8%). The use of overnight shelters increased by 9%.

Context: The percentage of clients abstinent or improved after treatment increased or remained stable for all types of treatment, as did clients' satisfaction with the ease of access to services. However, there is evidence that a harder-to-treat population has come with this increased demand. Among treatment clients, alcohol continues to decline as the most frequently used drug (72% in 1992-93, 68% in 1995-96 and 65% in 1996-97) and cannabis continues to increase (8% in 1992-93, 12% in 1995-96 to 13% in 1996-97) while cocaine shows a modest recent increase (8% in 1995-96 to 9% in 1996-97). The number of injection drug users seen in treatment increased by 17% over 1995-96. Demographically, the client population remains fairly stable with 55% of clients unemployed, 66% male and an average age of 35 years.

Prevention and Youth Treatment:

Key Change: 20% increase in treatment admissions for adolescents over 1995-96, almost double the 1992-93 treatment admissions and a 26% increase in prevention contacts.

Context: Efforts to provide easier access to prevention and treatment services for youth have contributed to increased treatment admissions and to prevention contacts. In 1996-97, 2,717 adolescents were admitted to treatment (8% of the 35,613 treatment admissions). Prevention and education contacts have also increased due to efforts to market training and to serve community interest in gambling problems.

Problem Gambling Treatment:

Key Change: Treatment admissions for problem gamblers have increased by 13% over 1995-96.

Context: AADAC's mandate was broadened to include problem gambling in 1994. New programs continue to be implemented to serve those who need treatment. In 1996-97, 2,617 problem gambling clients were admitted (7% of the 35,613 treatment admissions). Among problem gambling clients, the percent that most frequently uses VLTs increased from 57% in 1995-96 to 64% in 1996-97. As well, the *Gambling Help Line* dealt with 11% more crisis counselling calls in 1996-97 compared to the previous year.

B. Community Outpatient & Prevention Services

The network of community outpatient and prevention services provides a uniform core of services available throughout the province while allowing the development of special programs in response to individual community needs. The objective of these services is to increase the capacity of communities to effectively address issues related to alcohol, other drugs and gambling. Prevention and education services aim to prevent the development of abuse, promote health-enhancing behavior, or reduce the harms associated with problem gambling and the abuse of alcohol and other drugs. Education programs provide community members and allied professionals with knowledge and skills regarding addictions. Services available at the community level typically include school programs; information, education and training programs; prevention and harm reduction initiatives; assessment and referral services; individual, family and group counselling; and day treatment programs.

Figure 3

Community Outpatient and Prevention Services Results

Definitions

Efficiency
A measure of the total investment per client for each type of treatment or the total cost for each prevention contact

Access
Clients' rating of their ease of access to services

Effectiveness
Measured by client satisfaction and, for treatment, follow-up three months after the completion of treatment

Prevention/Education		**1994-95***	**1995-96**	**1996-97**
Service contacts*		147,094	126,004	158,974
Total investment*		$4,510,250	$4,506,016	$4,359,988
Efficiency	($ per contact)	$31	$36	$27
Access**	("definitely" easy to access training)	not available	not available	83%
Effectiveness**	(very satisfied)	not available	not available	76%
	(training "definitely" met expectations)	not available	not available	59%

Outpatient Counselling		**1994-95**	**1995-96**	**1996-97**
Treatment admissions		16,921	17,718	18,577
Total investment		$6,342,289	$6,812,300	$6,289,390
Efficiency	($ per admission)	$375	$384	$339
Access	(no difficulty accessing service)	not available	94%	94%
Effectiveness	(very satisfied)	88%	82%	79%
	(abstinent or improved after 3 months)	not available	84%	92%

Day Treatment***		**1994-95**	**1995-96**	**1996-97**
Treatment admissions		1,507	1,510	1,927
Total investment***		$1,923,767	$1,834,303	$2,292,937
Efficiency	($ per admission)	$1,277	$1,215	$1,190
Access		not available	(adolescents) 78%	94%
			(adults) 94%	
Effectiveness	(very satisfied)	not available	(adolescents) 91%	
			(adults) 83%	83%
	(abstinent or improved after 3 months)	not available	89%	94%

* *Contacts include prevention, education and training services. Provincial training services decentralized in 1995-96; 1994-95 figures adjusted for comparison.*

** *Based on Training Services. Indicators for other prevention/education services are under development. In addition to the 59% who answered "yes, definitely" when asked if training met expectations, an additional 37% answered "yes, I think so." As well, 83% would definitely recommend training services to a colleague.*

*** *1994-95 investments do not include residential services for adolescents. 1996-97 measures combine both adult and youth services.*

Overall, satisfaction with access to services has been maintained in the face of increased service use. Efficiency is generally improving, and the percentage of clients who are abstinent or improved after treatment has increased substantially across all Community Outpatient and Prevention services.

As well as the improvement in effectiveness reported above, day treatment clients report improvements in health (52.9% reported improvements in 1995-96, 65.0% report improvements in 1996-97) and employment/school situations (42.6% reported improvements in 1995-96, 48.0% report improvements in 1996-97). Consistent with

the business plans of AADAC and a number of its Funded Agencies, there has been some shifting of investment from short-term residential programs toward day treatment.

Satisfaction with services, though high, seems to be declining slightly in outpatient counselling. Consistent with more complex client needs, fewer outpatient clients report improvements in health (66.7% reported improvement in 1995-96, 55.0% reported improvement in 1996-97) and employment/school situations (58.7% reported improvements in 1995-96, 43.0% report improvements in 1996-97).

C. Crisis Services

Crisis services include detoxification programs, shelter programs, and the *Gambling Help Line*. Crisis intervention services attempt to protect the health and safety of clients while they withdraw from the effects of alcohol or other drugs, or deal with a gambling-related crisis. Crisis services are located regionally. Clients can contact these programs directly or through referrals from local AADAC and Funded Agency offices. The objective of detoxification services is to provide safe withdrawal from the extreme effects of alcohol and other drugs on an emergency basis. Shelter services provide a safe environment in which intoxicated individuals may spend the night. Shelter services are also a cost-effective and humanitarian alternative to jail.

Figure 4

Crisis Services Results

Efficiency
A measure of the total investment per client for each type of treatment or the total cost for each prevention contact

Access
Clients' rating of their ease of access to services

Effectiveness
Measure by client satisfaction and, for treatment, follow-up three months after the completion of treatment

Detoxification		**1994-95**	**1995-96**	**1996-97**
Treatment admissions		9,123	8,980	10,257
Total investment		$3,983,213	$4,438,263	$4,224,326
Efficiency	($ per admission)	$437	$494	$412
Access		not available	89%	89%
Effectiveness	(very satisfied)	not available	83%	83%
	(feel healthy enough to leave detox)	not available	59%	59%

Shelter Services		**1994-95**	**1995-96**	**1996-97**
Overnight stays		70,322	77,446	84,796
Total investment		$922,117	$1,020,096	$1,063,181
Efficiency	($ per overnight stay)	$13	$13	$13

Admissions to both detoxification and shelter have increased by 14% and 9% respectively, reflecting efforts to ensure access to services. Efficiency of both detoxification and shelter services has increased and effectiveness indicators remain stable.

There is some increased tendency for clients to leave detoxification early. The relative importance and implications of this trend are under investigation.

For 1996-97, in addition to the 59% who answered "Yes, definitely" when asked if they felt healthy enough to leave detoxification, an additional 33% answered "Yes, I think so." As well, 87% would recommend detoxification services to a friend or relative in need of similar help.

D. Residential Treatment

Residential treatment provides a more structured environment to aid successful recovery (compared to outpatient services) and is recommended for people with limited personal resources or more severe problems. Short-term residential programs are generally two weeks to one month long and are intended for clients who are severely dependent, lack support and require greater program structure. The objective of long-term residential treatment (generally one to three months, depending on client needs) is to provide clients without family and community supports with a structured living environment. Clients can then work towards establishing the employment and living situations necessary for reintegration after treatment.

Figure 5

Residential Treatment Results

Definitions

Efficiency
A measure of the total investment per client for each type of treatment or the total cost for each prevention contact

Access
Clients' rating of their ease of access to services

Effectiveness
Measure by client satisfaction and, for treatment, follow-up three months after the completion of treatment

Short-term	1994-95	1995-96	1996-97
Treatment admissions	4,241	4,335	4,203
Total investment	$8,221,097	$7,585,974	$7,340,508
Efficiency ($ per admission)	$1,938	$1,750	$1,746
Access (had "no difficulty" accessing services)	not available	93%	92%
Effectiveness ("very satisfied" with service)	83%	82%	83%
(abstinent or improved after 3 months)	94%	93%	94%

Long-term	1994-95	1995-96	1996-97
Treatment admissions	682	705	649
Total investment	$1,715,352	$1,637,162	$1,582,558
Efficiency ($ per admission)	$2,515	$2,322	$2,438
Access (had "no difficulty" accessing services)	not available	98%	94%
Effectiveness ("very satisfied" with service)	not available	88%	86%
(abstinent or improved after 3 months)	not available	not available	98%

Efficiency, access, satisfaction and effectiveness have been maintained although short-term residential treatment admissions and investment have declined (down about 3% each) over 1995-96. Long-term residential treatment admissions have also declined (down about 8%) as has total investment (down 3%). There has been a slight increase in the investment per admission. Access and satisfaction have declined slightly. Effectiveness measures are very high. These results are consistent with a planned focus on the clients for whom residential treatment is indicated.

Other indicators show trends of some concern. Consistent with more complex client needs, fewer clients in short-term residential treatment report improvements in health (72.7% reported improvements in 1995-96, 63.0% report improvements in 1996-97) and in employment/school situations (50.8% reported improvements in 1995-96, 44.0% report improvements in 1996-97).

E. Research, Information and Monitoring Services

The objective of research, information and monitoring services is to ensure prompt access to accurate and current information on issues, trends and research in the addictions field. Services include: production and distribution of current, high quality program materials, pamphlets, videos, etc.; provision of library services, dissemination of information on advances in addictions knowledge, transference of best practices through consultation, performance measurement, and program evaluation.

Figure 6

Research, Information & Monitoring Results

	1994-95*	1995-96	1996-97
Total investment*	$2,897,266	$2,577,427	$2,672,823
Information resources, communications & newsletters	633,118	613,762	548,665
Information development initiatives	141	268	193

* *1994-95 figures adjusted to reflect decentralization of training.*

Systems for monitoring performance of these services are under development. Funding for programs relating to gambling problems has increased the total investment in this area. Research and monitoring efforts have shifted significantly over the period to develop and support the emerging practice of performance measurement in AADAC. AADAC has been recognized for its leadership in performance monitoring.[12]

There has been a deliberate shift toward producing "master copies" for others to copy for distribution and away from producing quantities of finished brochures and information pieces. This approach reduces costs while maintaining availability of information.

IV. Investment and Returns

The question of whether investment in addictions services produces reasonable benefits is very broad. Prevention and treatment services for addiction to alcohol, drugs and gambling are investments in the economic future of the province which produce returns both to the individual and to society. Individuals gain increased health, productivity and income as well as less tangible benefits such as greater personal resources and family unity. The benefits to society include a reduction or elimination of costs that would have been incurred had the addictions treatment not taken place.

The question is addressed in three ways. First, AADAC compares the relative investment per capita between Alberta and Manitoba as the populations, relevant networks of services, cost structures and other pertinent features of the two provinces are reasonably similar. Second, AADAC compares treatment outcomes with the available literature for similar types of treatment, types of clients, types of measures and measurement methodologies. Third, an analysis of the costs of addiction and returns on investment in addiction programming is conducted periodically.

An increase in admissions per 100,000 population in Alberta (and a slight decline in Manitoba) shows that access to AADAC services has been increased in 1996-97. With similar levels of need for service, Alberta had 1,277 admissions per 100,000 in 1996-97, compared to Manitoba admissions of 1,270. Expenditures per capita were $10.42 in Alberta in 1996-97 compared to $11.18 in Manitoba. For both provinces, per capita investment remained stable compared to the previous year.[13] Over all, AADAC achieved similar rates of access to service at less cost than Manitoba.

The available treatment literature commonly reports abstinence rates for evaluated treatment programs and cautions that abstinence rates measure only a part of the value and success of treatment. While there are many approaches to broadening success measures in addictions treatment, there is little consensus on what to include and how to measure and report it. AADAC is mindful of the risk in using abstinence rates as the only indicator of success and includes other indicators in its performance measurement. It is worthwhile, though, to provide a comparison of AADAC services to the relevant academic findings. The following table summarizes findings from studies of programs similar to AADAC's that have been conducted in a comparable way.

Figure 2

Comparison of outcomes for AADAC services and the services reported in the addictions literature[14]

Type of Service	Abstinent	Abstinent or improved*	Satisfaction with services
AADAC outpatient counselling	**48%**	**92%**	**79%**
Comparable outpatient counselling	16% - 54%	84%	69%
AADAC day treatment	**56%**	**94%**	**83%**
Comparable day treatment	38%	77%	86%
AADAC short-term residential	**64%**	**94%**	**83%**
Comparable short-term residential	28% - 66%	53% - 84%	92%
AADAC long-term residential	**65%**	**98%**	**86%**
Comparable long-term residential	59%	Not known	Not known

* *Methods of determining post-treatment abstinence are reasonably comparable; methods of determining "abstinent or improved" status vary considerably. AADAC uses clients' post-treatment reports of reduction in alcohol, drug and gambling as an indication of "improvement." Therefore, if a client is abstinent continuously for the three months following treatment or reports reduced use of alcohol, drugs or gambling for this period as compared to pre-treatment, they are counted as "abstinent or improved."*

The table shows that AADAC's services compare favorably to the available addictions literature.

Addictions problems occur at all levels of society and within communities throughout the province. As a result, individuals and families suffer and substantial costs are incurred by the health care and justice systems, by business and industry and by the community at large. A recent Canadian study[7] has estimated that alcohol use cost Alberta $749 million in 1992, tobacco use cost $728 million and illicit drug use cost $135 million. The total cost calculated was $1.6 billion (2.2% of the gross domestic product) or over $600 for each individual in the province. There is little research on estimating the costs of problem gambling in Canada. However, one Manitoba study estimates the cost per problem gambler at $56,000 per year.[15]

A recent review of the literature[15] on economic evaluations of substance abuse has shown that investment in treatment programs is generally recovered within one to three years through reduced demands on health care, social services and the criminal justice system. Estimates of the return from each dollar invested in a substance abuse program one year after treatment (from a tax payer perspective) range from $4.31 to $12.58. The overall average return on investment was $7.14. The studies examined support the contention that investment in addiction services produces a return through a reduction or elimination of cost that would have been incurred had the service not been available. Cost-benefit analyses studies of treatment for problem gambling are not available.

V. Summary and Conclusion

A. Summary

Quality service means that Albertans are satisfied that AADAC has balanced accessibility, effectiveness and efficiency. Overall, AADAC services have shown increased effectiveness and efficiency and continued client satisfaction with access and services. The productivity of addiction services has increased. Compared to 1992-93, the Commission is serving 14% more treatment clients, providing 13% more prevention. As planned, investments have shifted toward community service, crisis services and non-residential treatment, and efficiency has been sustained or increased. Some initial gains appear to have been made in treatment effectiveness.

Services for youth have been restructured, contributing to increased prevention and treatment service accessibility. Gambling services continue to be implemented and integrated into service delivery systems and have also resulted in increased prevention and treatment service delivery. As a consequence, these services are easier to access for those who need them.

Alberta and Manitoba provide roughly similar levels of service and expenditures for addictions per capita. Treatment outcomes for the Commission are comparable to those found in the addictions treatment literature. Addiction services continue to provide a good return on investment. The rate of return to taxpayers ranges from $4.31 to $12.58 per dollar invested, depending on the circumstances, as clients return to productive employment, reduce their criminal activity and decrease their use of health care.

In looking ahead, we have to anticipate challenges. There is evidence that clients are becoming more difficult to treat, with multiple addictions and injection drug use more prevalent; as well, staff have observed greater levels of medical and psychological distress among clients referred. Staff have also observed that women coming to treatment are more likely to use multiple substances, to be long-term heavy users and have problems in other life areas than they were in the past. There is ongoing public demand for services, and ongoing concern about addiction issues. This is reflected in continued funding requests, in increasing demand for service, and in the responses offered at community consultations held by AADAC's Board. Some indicators of clients' health and changes in drugs of abuse suggest that a "weather eye" should be kept on the extent to which AADAC can maintain its current high levels of client satisfaction and positive outcomes.

B. Conclusion

It is important, in drawing conclusions about performance, to consider the context in which services are delivered. Substance abuse and problem gambling are concerns for Albertans. Thirty percent (30%)[16] of Albertans indicate that they or someone they are close to have had a problem as a result of the abuse of alcohol or other drugs. When so many people are affected by problems related to addictions, it is vitally important that we continue to provide services that address problem gambling and substance abuse. AADAC and its funded agencies, in partnership with other Government departments, regional authorities and community-based organizations, work to provide an integrated system of services available locally, regionally and provincially.

It is fortunate that addictions problems are amenable to treatment and prevention. Also, unless there are medical complications, most addiction problems can be treated at the community level, using outpatient counselling methods rather than more expensive hospital-based medical interventions.

AADAC's performance in the 1996-97 fiscal year is unequivocally positive. Services are not only of reasonable quality but have improved on many dimensions. The best available evidence shows that addiction services produce good returns for tax dollars spent.

However, this is not the time for complacency. At a societal level, indications are that the downward trends in substance use over the last 15 years have slowed or, in some cases, even reversed. There is evidence of increased use of some drugs such as marijuana and LSD and an increase in the number of HIV infections attributable to injection drug use. Addiction, whether to alcohol, other drugs or gambling, remains a serious problem that affects all Albertans. As such, it must be addressed at the individual, family and community level. The need to be vigilant remains.

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